Form Information

Member Claim Form

Not to be used for Pharmacy or Dental claims

Insured and/or Administered by
Connecticut General Life Insurance Company
and CIGNA HealthCare of Arizona, Inc.

CIGNA®

This form can be used for CIGNA Medicare Access® (PFFS) plans only.
This form only needs to be completed if the provider is not submitting the claim on your behalf.

Please refer to reverse side for instructions.

MEMBER INFORMATION: *Member complete this section*

A. Member's Name *(Last Name, First Name, Middle Initial)*

B. Date of Birth MM | DD | YYYY

C. Member's Mailing Address *(No., Street)* | *(City)* | *(State)* | *(Zip Code)*

Daytime Telephone # ( )

Is this a change of address? ☐ Yes ☐ No
(Note: address must also be changed with Employer)

D. ID Number *(on the front of your CIGNA ID card)*

EMPLOYER INFORMATION (IF APPLICABLE)

A. Employer Name

B. Group No. *(on the front of your CIGNA ID card)*

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:
Complete only if claim is a result of an accident or occupational (work related) illness/injury

A. Accident or Illness due to employment? ☐ Yes ☐ No

B. Injury due to auto accident? ☐ Yes ☐ No

C. Description of how accident or work related illness/injury occurred

D. Date of accident or beginning of illness MM | DD | YYYY

E. Are you filing a claim or lawsuit against a third party including an insurance company in order to recover the cost of expenses incurred as a result of this accident or illness? ☐ Yes ☐ No If yes, Name of Third Party:_____

OTHER COVERAGE INFORMATION: *Complete only if other coverage is in effect*

A. Are you covered under another employer group health insurance plan? ☐ Yes ☐ No If yes, provide:
Name of Health Insurance Company | Effective Date of Coverage MM | DD | YYYY | Policy Number | Type of Plan (HMO or PPO) if known

B. Spouse Employed? ☐ Yes ☐ No If No, has spouse been employed during last 12 months? ☐ Yes ☐ No

C. Name of Spouse *(Last Name, First Name, Middle Initial)* | Spouse's Date of Birth MM | DD | YYYY | D. Name of Spouse's Employer

Address of Spouse's Employer *(No., Street)* | *(City)* | *(State)* | *(Zip Code)* | Telephone # ( )

IF YES TO A OR B, ENCLOSE A COPY OF THE EXPLANATION OF BENEFITS (EOB) WITH THIS FORM AND THE ITEMIZED BILL(S).

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

I certify that the information supplied is true and correct.

MEMBER'S SIGNATURE
X

DATE MM | DD | YYYY

PAYMENT INSTRUCTIONS

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

MEMBER'S SIGNATURE
X

DATE MM | DD | YYYY

NOTE: The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration.

Clear Fields

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INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT

1. **This form can only be used for CIGNA Medicare Access® (PFFS) plans.** This form only needs to be completed if the provider is not submitting the claim on your behalf.
2. If you received this claim form electronically, you can fill in the fields by clicking to the right of the first field (Member's Name) and typing in the information. Remember to click on the Clear Fields button on the top of page 1 after printing out the completed claim form.
3. If you are completing this form by hand, use a new printed form rather than a photocopy to ensure the form can be scanned into our system. Also, be sure to print clearly and use black ink when you complete the form.
4. Claim must be postmarked within one year of your date of service for claims to be considered payable.
5. Use a separate claim form for each provider. A new form can be obtained from www.cignamedicare.com under Resources for: Members, CIGNA Medicare Access (PFFS), Forms or by calling Member Services using the toll-free number on your CIGNA ID card.
6. Your claim cannot be processed without your ID Number (Member Section, Block D). Please reference the front of your CIGNA ID card to find this number.
7. You must submit an itemized bill for your claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill.
8. ITEMIZED BILLS MUST INCLUDE:

Member Name	Provider Name	Date of Service
Type of Service	Provider Address	Diagnosis
	Provider Tax ID Number	Charge for Service

9. We suggest you make a copy of your bill(s) and your completed claim form for your records. If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.
10. Please be aware that payment will be sent to the provider, unless you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and this claim form. CIGNA reserves the right to request additional documentation, such as medical records prior to processing your claim.
11. If you have coverage through another health insurance carrier which is considered primary (CIGNA as secondary), you must submit the Explanation of Benefits (EOB) from the insurance carrier for this service along with this completed form and itemized bill.

EXPLANATION OF BENEFITS

You will receive a weekly Explanation of Benefits (EOB) explaining the charges applied to your deductible and any charges you owe to the provider. Please keep your EOBs for later reference.

MAILING INSTRUCTIONS

If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.

Send your ***completed claim form*** and itemized bill(s) to the **CIGNA address listed on your identification card.**

If you have additional questions, please contact Member Services using the toll-free number on your ID card.